Healthy Indiana Plan 2.0

HEALTHY INDIANA PLAN℠

Health Coverage = Peace of Mind

HIP 2.0: Basics

Who is eligible for HIP 2.0?

- Indiana residents*
- Age 19 to 64*
- Income **under 138%** of the federal poverty level **(FPL)***
- Not eligible for Medicare or other Medicaid categories*
- Also includes individuals currently enrolled in:
  - Family planning services (MA E)
  - Healthy Indiana Plan (HIP)
  - Hoosier Healthwise (HHW)
    - Parents and Caretakers (MAGF)
    - 19 and 20 year olds (MA T)

Monthly Income Limits for HIP 2.0 Plans

# in household	HIP Basic Income up to 100% FPL	HIP Plus Income up to ~138% FPL**
1	$973	$1,358.10
2	$1,311	$1,830.58
3	$1,650	$2,303.06
4	$1,988	$2,775.54

*Adults not otherwise Medicaid eligible who have children must make sure their children have minimum essential coverage to be eligible for HIP

**133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.

HIP 2.0 Basics

When does service coverage begin?

- February 2015, pending federal approval
- HIP & applicable HHW members converted to HIP 2.0 without having to reapply
- New applicants submit Indiana Application for Health Coverage to be considered for HIP coverage
  - **No longer using separate HIP application**
  - No retroactive coverage

What types of services are covered?

- HIP **Basic** members
  - Minimum Essential Coverage providing Essential Health Benefits
- HIP **Plus** members
  - HIP Basic benefits with additional services including:
    - Vision
    - Dental

Transition to HIP 2.0

Who provides services to HIP 2.0 members?	• Eligible providers must enroll:*
	  • With Indiana Medicaid as an Indiana Health Care Provider
	  • With Managed Care Entity (MCE) to provide in-network services to HIP members
	• All HIP members will have a Primary Medical Provider (PMPs)

Who pays for services?	• HIP member
	  • POWER account debit card** and/or copayment***
	• Risk-based MCEs
	  • Anthem
	  • MDWise
	  • Managed Health Services (MHS)

How will members be placed in a MCE?	• Current members will stay with current MCE
	• New members select MCE
	  • On application **OR**
	  • Call enrollment broker after application **OR**
	  • Auto-assigned by HP

How should one answer member questions?	• Refer members to their MCE
	  • Anthem: (866)800-8780
	  • MDWise: (800)356-1204
	  • MHS: (877)647-4848

*Does not include emergency service providers
**All plans should have POWER account debit card by June 2015
***Individuals with copayment obligation cannot use POWER account to pay copayment.

Eligibility Verification

- ✓ You will still be able to verify member eligibility via normal processes
- ✓ Verification will indicate member's benefit plan and cost sharing responsibility

Benefit Plans	Copayments	Special Flags
HIP Basic	Copayments for services – check card or contact MCE for values	Pregnancy – maternity services included
HIP Plus	No copayments	Low-income populations – facility services paid at Medicaid rates
State Plan Plus		
State Plan Basic		

Cost Sharing

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1. Member does not pay copayment after 5% of household income spent on out-of-pocket health care costs
2. Pregnant women and Native Americans exempt from cost sharing
3. Provider cannot deny service based on member inability to pay

HIP Basic Plan: Cost Sharing

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic members are responsible for the following copayments for health and pharmacy services.

Service	HIP Basic Copay Amounts Income ≤100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

Copayments may not be more than the cost of services received.

Emergency Department (ED) Copayment Collection

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- ✓ HIP requires non-emergent ED copayments unless:
  - Member meets cost sharing maximum for the quarter
  - Member calls MCE Nurse-line and is told to go to ED
  - The visit is a true emergency
- ✓ HIP features a graduated ED copayment model
  - Providers should call the MCE to determine the member's copayment at each non-emergent ED visit

The Medically Frail

What is Medically frail?

- Required federal designation
- Individuals with certain serious physical, mental, and behavioral health conditions are required to have access to the standard Medicaid benefits
  - Called HIP State Plan benefits

What conditions make someone "medically frail?"

- Disabling mental disorders (including serious mental illness)
- Chronic substance use disorders
- Serious and complex medical conditions
- A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living
  - Activities of daily living include bathing, dressing, eating, etc.
- A disability determination from the Social Security Administration

Medically Frail: Benefits and Cost Sharing

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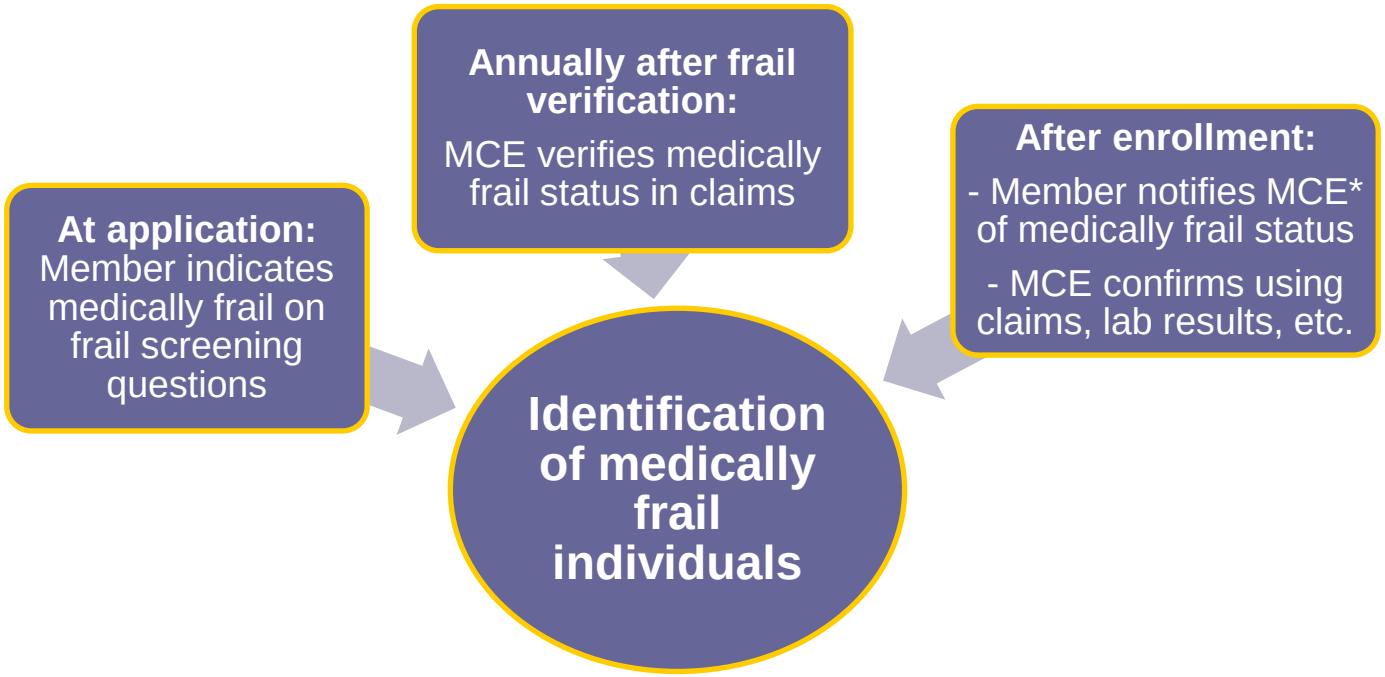
What benefits do medically frail receive?

- HIP State Plan benefits are comprehensive and at least as generous as benefits offered in HIP Basic and HIP Plus and include:
  - Vision
  - Dental
  - Non-emergency transportation
  - Other Medicaid State Plan benefits

What out-of-pocket costs will medically frail individuals have?

- Required to pay HIP cost-sharing of their chosen program:
  - HIP Plus - Monthly POWER account contribution (PAC)
    - Available for individuals with income up to ~138% FPL
    - If fail to pay PAC, must pay copayments for services until outstanding PAC paid
  - HIP Basic - Copayments for services
    - Available for individuals with household income less than or equal to 100% FPL

Medically Frail Identification

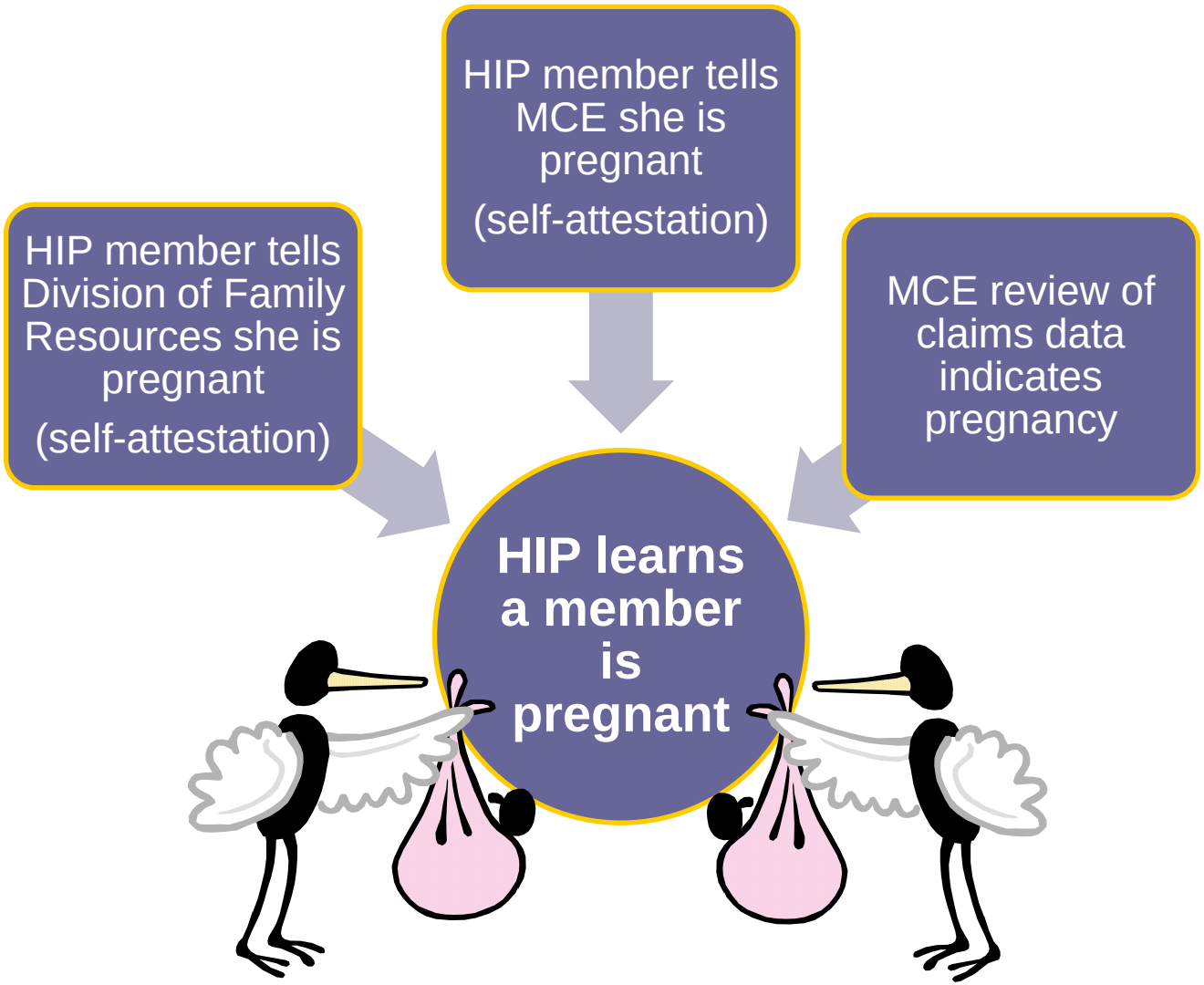


<u>Provider Impact</u>:

- **Information request from managed care entity (MCE)**:
  - MCE verifying member medically frail status
- **Eligibility verification provides information for**:
  - Member medically frail status & access to HIP State Plan benefits

*Only MCE can review medically frail status; so member will not notify Division of Family Resources of medically frail status

Pregnancy Determination



HIP Coverage for Pregnant Women

Woman becomes pregnant while enrolled in HIP

- HIP member becomes pregnant
- Additional pregnancy-only benefits begin
  - No cost sharing during pregnancy/post-partum period
  - OPTION: May request to move to HIP Maternity (MAGP)

Woman is pregnant at application or redetermination

- Woman eligible for HIP 2.0 and is pregnant at the time of application or at her annual redetermination timeframe will receive HIP Maternity (MAGP)
  - No cost sharing during pregnancy/post-partum period
  - May have coverage gap when reentering HIP after pregnancy if end of pregnancy not reported on time

RECOMMEND:
Report end of pregnancy promptly to guarantee continued HIP coverage without a gap

Pregnancy Benefits

- ✓ Pregnant women receive benefits only available to pregnant women, regardless of selected HIP plan
  - Exempt from cost sharing
  - Additional benefits continue for a 2 month post-partum period

Additional Benefits Include:
Vision
Dental
Non-emergency transportation
Chiropractic

Pregnancy Benefits, cont.

How long will maternity services be covered?

- Up to two months (60 days) post-partum
  - Woman must report end of pregnancy BEFORE end of 60 day post-partum period to avoid coverage gap

How will member costs change for pregnant women?

- There is no cost sharing for pregnant women
- POWER account is frozen during pregnancy/post-partum period
- No cost sharing for HIP 2.0 or HIP Maternity (MAGP) during pregnancy/post-partum period

How will health care provider know maternity benefits status?

- Eligibility verification will show provider:
  - Maternity benefits coverage
  - No cost sharing obligation

Reimbursement Rates

HIP Reimbursement Rates

- Medicare Rates
- 130% of Medicaid rate if no Medicare rate exists

Exceptions

- Inpatient claims for Low Income Parents, Caretakers and 19 and 20 year olds are reimbursed at the Hoosier Healthwise rate